

2004 Annual Report **on Integrated Services Projects and** **Coordinated Services Team Initiatives**

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For additional copies of this report, or for more information on
Wisconsin's Collaborative Systems of Care, please visit:

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"I look at my kids today and have living proof that the team process works."

*- Ann Hagar, Parent
(Used with permission, 7/28/05)*

This report is written for the Children Come First Advisory Committee, the group statutorily responsible for monitoring the development of Integrated Services Projects in Wisconsin. This report highlights the accomplishments and challenges faced by Collaborative Systems of Care in Wisconsin, namely the Integrated Service Projects (ISPs) and Coordinated Services Team Initiatives (CSTs).

Wisconsin's Collaborative Systems of Care go by many names: the Coordinated Services Team Initiative (CST), Integrated Services Projects (ISP), and "Children Come First" (CCF) are all names of projects which use the wraparound process to respond to individuals and families with multiple, often serious needs in the least-restrictive setting possible. This wraparound process is based on family and community values and is unconditional in its commitment to creatively address needs. Services are developed by child- and family-centered teams that support community-based options. Each team develops an individualized plan, which incorporates strengths of the child, family, and team members to work toward identified goals. Parents/caregivers are equal partners and have ultimate ownership of their Plan of Care.

"I couldn't be where I am today without my team."

*- Tyler, Youth
(Used with permission, 7/28/05)*

BACKGROUND

Wisconsin has been developing Collaborative Systems of Care since 1989. The original initiatives, ISPs, focused on supporting families with children with Severe Emotional Disabilities (SED) in their homes and communities.

In 2002, the collaborative process employed by ISPs was expanded with the development of CSTs. While CSTs use the same process as ISPs, the target group has been expanded to

include children and families who do not necessarily have an SED diagnosis but who have complex needs and are involved in multiple systems of care (e.g. substance abuse, child welfare, juvenile justice, and/or mental health).

In 2004, 34 counties received funding through contracts with the Bureau of Mental Health and Substance Abuse Services (BMHSAS). The funding includes Mental Health Block Grant funds, Substance Abuse Grant funds and Hospital Diversion funding. The Division of Children and Family Services in collaboration with BMHSAS also provided funding for CST sites.

COUNTIES WITH INTEGRATED SERVICES PROJECTS

Ashland	Marquette*
Chippewa	Portage*
Door	Racine
Dunn	Rock
Eau Claire	Sheboygan
Fond du Lac	Washburn
Kenosha	Washington
La Crosse	Waukesha
Marinette	Waushara

COUNTIES WITH COORDINATED SERVICES TEAM INITIATIVES (SITES ADDED 2002 – 2003)

Bayfield	Manitowoc
Calumet	Marquette*
Green Lake	Portage*
Iron	Sauk
Jefferson	Waupaca

COUNTIES WITH COORDINATED SERVICES TEAM INITIATIVE (SITES ADDED IN 2004)

Adams	Pierce
Crawford	Polk
Douglas	Richland
Grant**	St. Croix
Lafayette	

* Marquette and Portage Counties have both ISP and CST initiatives

** Grant County is developing its project with limited funds for training and technical assistance

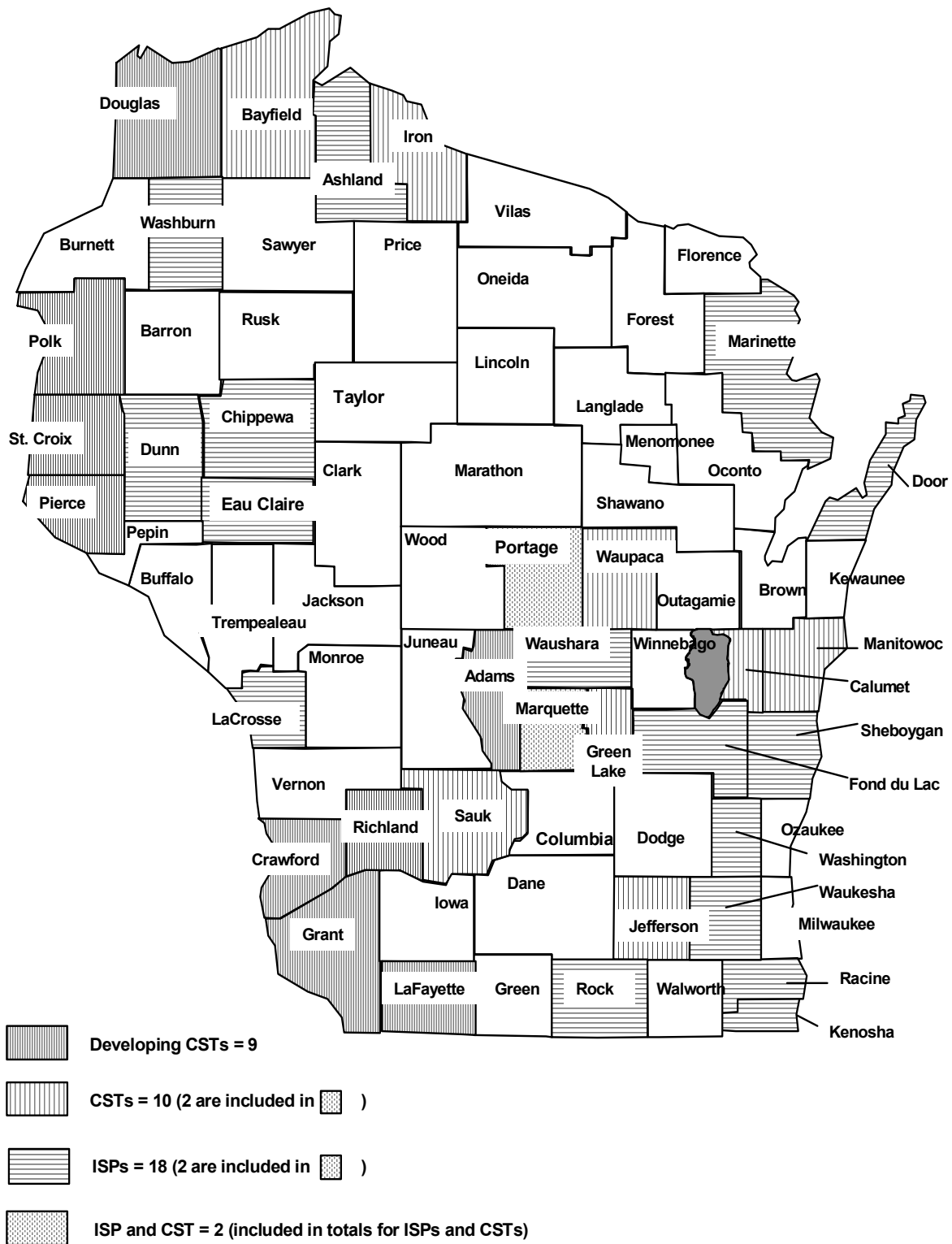
A Picture of Children's Mental Health

Compiled by Wisconsin Family Ties, February 2004

www.wifamilyties.org

- One in five young people have at least one diagnosable mental or addictive disorder according to the U.S. Surgeon General. [U.S. Dept. of Health and Human Services, 2001]
- 79,996 Wisconsin children ages 9 – 17 suffer from a major mental illness that results in significant impairments at home, at school, and with peers. [Estimated prevalence in U.S. Surgeon General's Report, 1999]
- Only about 20% of children with mental illness receive needed treatment in any given year. Unmet need for services remains as high now as it was 20 years ago. [U.S. Surgeon General's Conference on Children's Mental Health, 2000]
- The high school non-completion rate for children with emotional and behavioral disorders is 56%, highest of all disability groups and twice the rate of the general population. [O'Leary, Wisconsin Statewide Transition Conference, 2004]
- Among 6 to 17-year-olds in foster care, about 40% meet the criteria for a mental illness diagnosis with moderate impairment. [U.S. Surgeon Generals Conference on Children's Mental Health, 2000]
- In a recent Child and Family Services Review, Wisconsin failed to meet the benchmark for "children receive adequate services to meet their physical and mental health needs." The report observes, "There is a problem accessing mental health services for children...because their families usually do not have medical insurance that will cover mental health services." [U.S. Dept. of Health and Human Services, Wisconsin Child and Family Services Review, 2004]
- Suicide is the second leading cause of death for Wisconsin young people. [Wisconsin Suicide Prevention Strategy, May 2002] More than 90% of adolescents who take their lives have a mental health disorder such as depression. [U.S. Surgeon General's Conference on Children's Mental Health, 2000]
- In response to health screenings conducted at admission to juvenile justice facilities, 73% of juveniles reported having mental health problems and 57% reported having prior mental health treatment or hospitalization. [Office of Juvenile Justice and Delinquency Prevention Study, 1994]
- Child mental health disorders persist into adulthood: 74% of 21-year-olds with mental health disorders had prior problems. [U.S. Surgeon General's Conference on Children's Mental Health, 2000]

A STATEWIDE LOOK AT COLLABORATIVE SYSTEMS OF CARE SERVING CHILDREN AND FAMILIES IN 2004

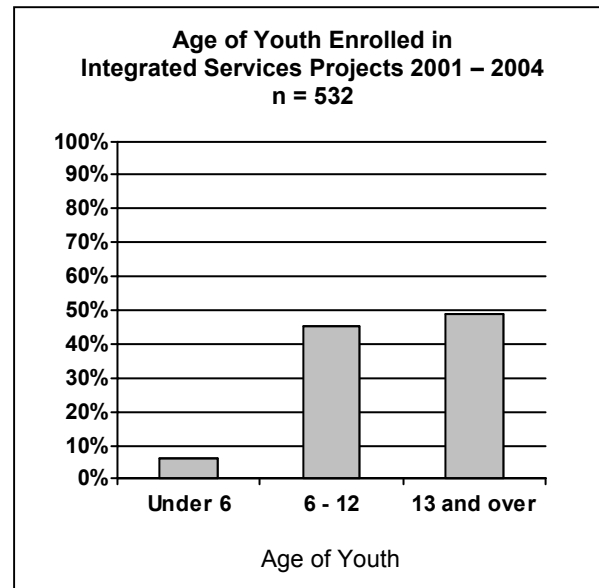
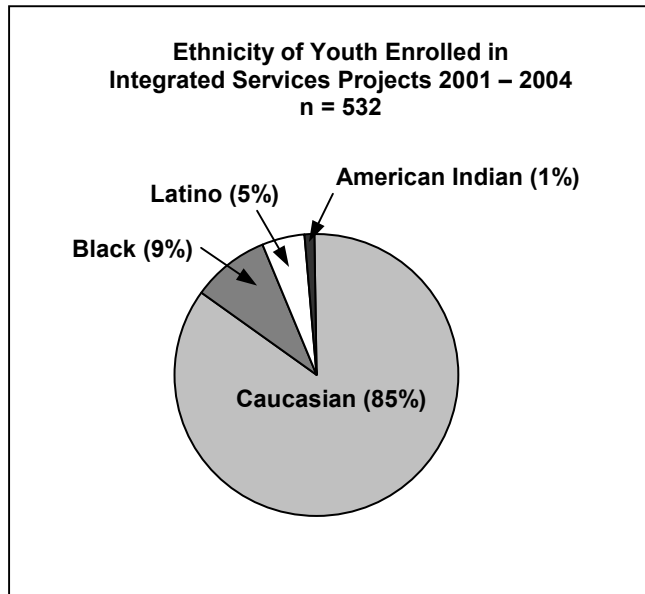


QUARTERLY REPORT DATA

The following information is based on data from counties with Integrated Service Projects (ISP) who submitted data quarterly to the State Bureau of Mental Health and Substance Abuse Services.

Demographic Information

Information from 532 youth with Severe Emotional Disabilities has been collected from 2001 to 2004. Of these, 70% were male and 30% female, with an average age of 12.8 years.



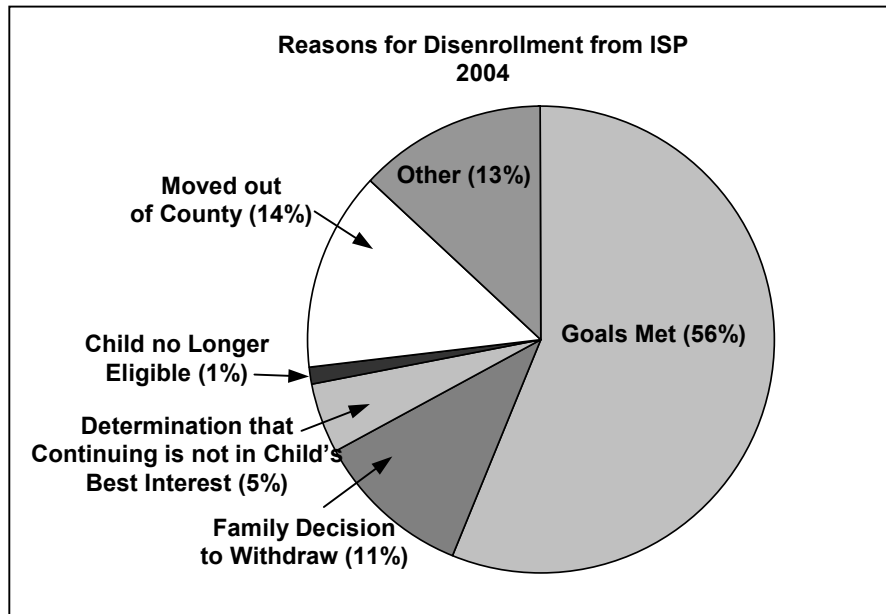
Disenrollment/Transition Out of ISP

The average length of time from when a child/youth was enrolled in ISP to the time of disenrollment in 2004 was 19.2 months.

Reasons a child and family may be disenrolled from ISP include:

- **Goals Met:** All team members (including family) agree that the goals outlined in the Plan of Care have been met. The family has a voice in decisions made concerning their child and family, access to services they need, and ownership of their Plan of Care.
- **Family Decision to Withdraw:** Families may choose to withdraw for various reasons. Some examples include: family situation changes and a family no longer desires team support; family believes there is a less intensive way to get their needs met.
- **Moved out of County:** If the child is no longer a resident of the county, he/she may no longer be eligible to receive services from that county.
- **Child No Longer Eligible:** A child is no longer eligible for the Integrated Services Project if he/she no longer meets criteria for Severe Emotional Disturbance (SED), and/or the child no longer meets age requirements.
- **Determination by the Team not to Continue:** A team may make a decision to end the ISP process; reasons may include: goals aren't being met, team process isn't moving forward, or lack of team trust or cooperation among team members.
- **Other:** This category serves as a "catch all" for disenrollment reasons that do not clearly fit into other categories.

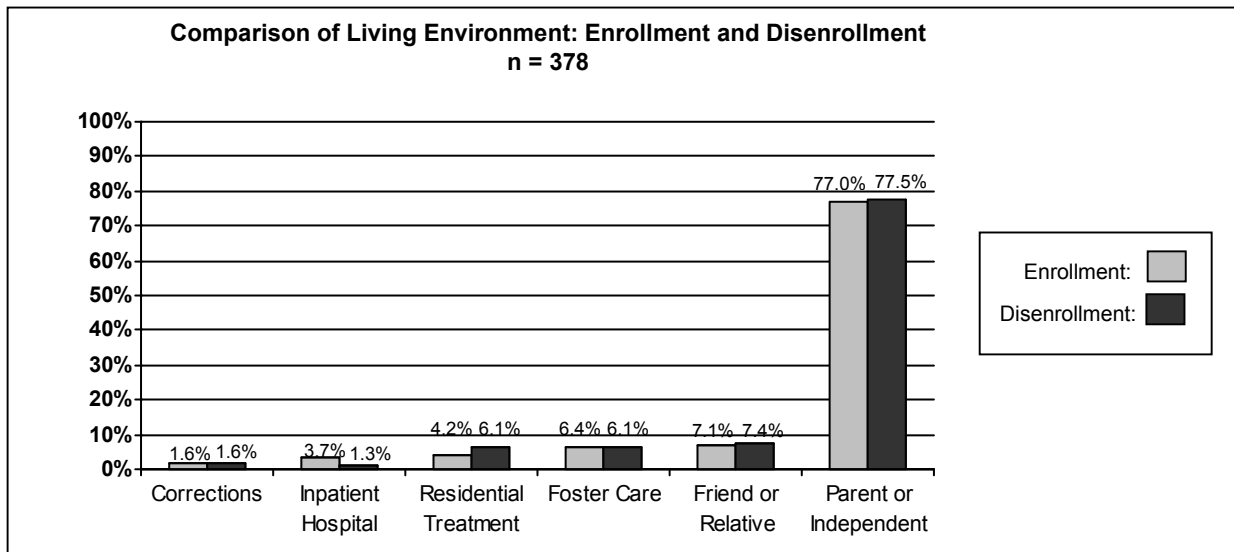
The chart on the next page summarizes reasons for disenrollment from ISP in 2004:



Changes in Restrictiveness of Living Environment – Youth Enrolled and Disenrolled 2001 to 2004

One of the characteristics of youth enrolled in ISP is that they are at risk of out-of-home placement. This risk is determined by many factors including: past out-of-home placements, despite multiple supports and services being in place behavior does not improve, or parents and service providers are considering placement out of home/school/community at time of referral.

Integrated Services Projects strive to support youth and their families in the least restrictive setting possible. The most notable change in living environment occurred in the number of youth in inpatient hospital settings. Fourteen (14) youth were hospitalized at time of enrollment; at time of disenrollment five (5) youth were in such a placement. The number of youth in residential treatment facilities increased by about the same amount as the decrease in the number of hospitalized youth indicating a decrease in the restrictiveness of the living situation.



Behavioral Functioning at Home, School, and in the Community

One of the tools used to collect data is the Child and Adolescent Functional Assessment Scale (CAFAS). The CAFAS is a nationally-recognized instrument developed by Kay Hodges, PhD. which provides a “behavioral snapshot” of a child’s functioning across eight subscales: role performance at school, role performance at home, role performance in the community, behavior toward others, moods and emotions, self-harmful behaviors, substance use, and thinking. Changes over time in individual subscale scores, as

well as changes in total scores, serve as indicators to teams of where a child has improved and in what areas more improvement is possible.

Counties with Integrated Services Projects are asked to rate youth using the CAFAS at enrollment and every 6 months thereafter. The rater, using information gathered from the family, natural supports, and service providers, considers a variety of possible indicators to assign a score of 0, 10, 20, or 30 on each of the eight subscales listed above, with 0 indicating *no impairment* and 30 indicating *significant impairment*.

Results of averaging all CAFAS scores collected for each subscale during the years 2001 to 2004, regardless of when a child's treatment began or ended or when the CAFAS was administered, show that children enrolled in ISP have the most impairment at home and school (subscale scores were 18 and 17, respectively). Children scored the lowest in the areas of self-harm behavior and substance use (subscale scores were 5 and 2, respectively).

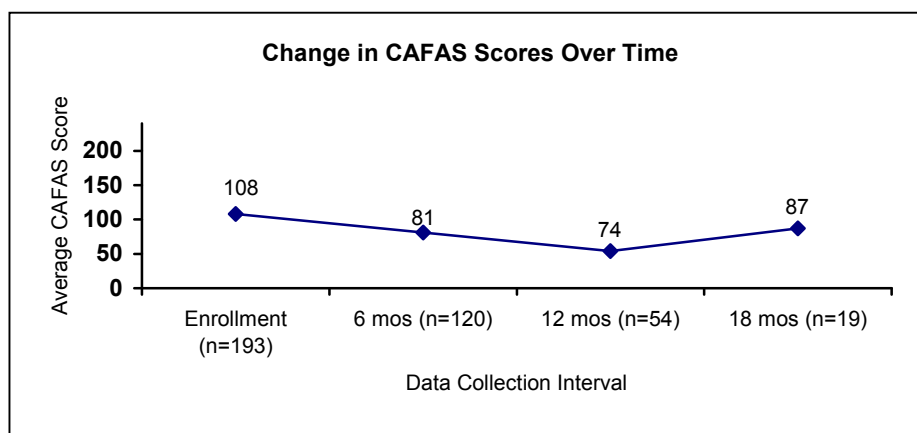
The total score on the CAFAS (scores from each of the subscales added together) can range from 0 to 240. The chart that follows illustrates Dr. Hodges' interpretation of a youth's total score:

CAFAS Scoring: Total Score*	
8-Scale Sum	Description
0 – 10	No noteworthy impairment
20 – 40	Youth can likely be treated on an outpatient basis
50 – 90	Youth may need additional services beyond outpatient care
100 – 130	Youth likely needs care which is more intensive than outpatient and/or which includes multiple sources of supportive care
140+	Youth likely needs intensive treatment, the form of which would be shaped by the presence of risk factors and the resources available within the family and the community

*Taken from "CAFAS Self-Training Manual", Kay Hodges, PhD.

Changes in CAFAS Scores over Time: The following graph reflects data collected 2001 to 2004 for 193 youth who were rated using the CAFAS at time of enrollment. As shown, 120 of the 193 children were also rated after 6 months of enrollment; 54 of the 193 children were rated at both 6 and 12 months; and 19 children from the original 193 were rated at all four intervals (enrollment, 6 months, 12 months, and 18 months).

One possible explanation for the increase in scores from 12 to 18 months is the low sample size (19) available at 18 months. Another explanation may be that children who continued to be enrolled at 18 months most likely experience the most challenges and therefore need continuing support. The fact that there were only 19 of 193 children rated both at the time enrollment and 18 months later reflects the need to improve the consistency of data collection among ISP sites.



Counties with Integrated Services Projects (ISP) and Coordinated Services Team Initiatives (CST) are asked to fill out an annual survey to capture information on enrollment (summarized in Part A of this section) and the impact of their collaborative initiative on the larger service system (summarized Part B of this section).

The following incorporates data submitted by 25 sites that completed the survey (15 ISP, 8 CST, and 2 that have both ISP and CST initiatives).

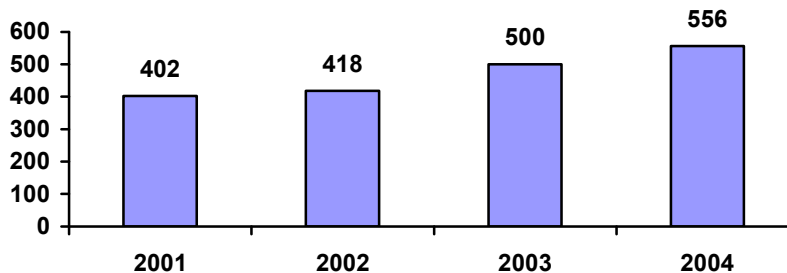
PART A: Enrollment Information

The number of child and family teams for which evaluation data is collected and reported to the State is only a partial indicator of the actual number of individuals served by collaborative systems of care in Wisconsin. Each site collects evaluation data on only a portion of the children served due to resource constraints. The child and family teams for which sites collect and report evaluation data to the State are referred to as “formal enrollments”; the additional child and family teams served by each site are referred to as “informal enrollments”. “Informal” teams are expected to adhere to the same key principles and values as “formally” enrolled teams.

Formal Enrollment:

In 2004, there were **556** formally enrolled teams reportedly being served by CST and ISP initiatives across Wisconsin. The average length of enrollment per child and family team was 17.6 months. The average number of teams per county was 21, ranging from 3 in a site just starting out to 86 teams in a well-established site. The graph below summarizes the number of formally enrolled teams over the past 4 years:

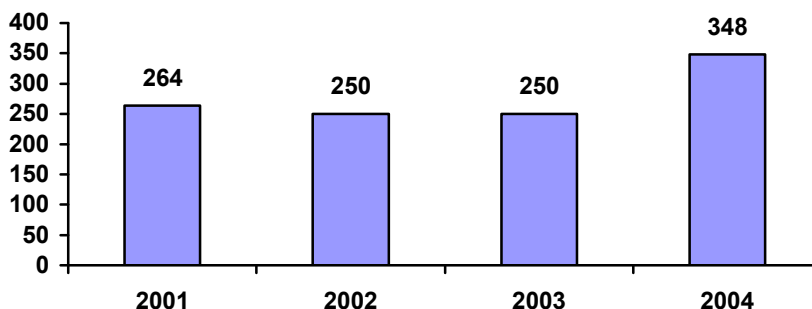
Formally Enrolled Child & Family Teams 2001 - 2004



Informal Enrollment:

In 2004, CST and ISP sites reported serving **348** “informal” teams. The graph below summarizes teams being served “informally” over the past 4 years:

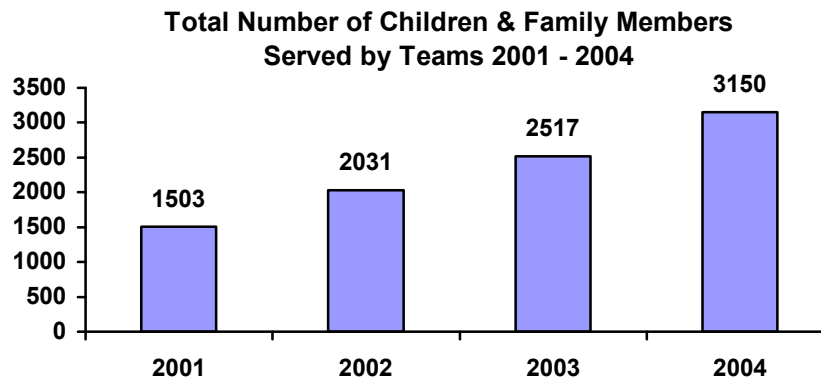
Informal Child & Family Teams 2001 - 2004



Total Children and Family Members Served:

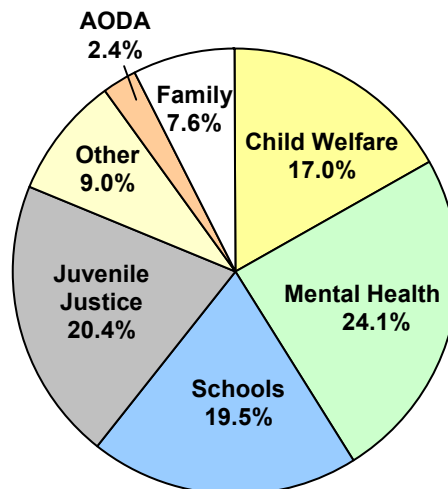
In addition to identifying the number of teams/identified children served, sites were asked to report the number of family members other than the identified child who received support and services that they may not have received if the family had not been involved in the team process. In 2004 there were **2,246** additional family members served, an average of 90 people per county and 2.5 family members per team.

The total number of children and family members served in 2004 was **3,150** (904 children and 2,246 additional family members). The graph below summarizes the total number of children and family members served over the past 4 years.



Referral Source:

The chart below summarizes sources of referrals made to Collaborative Systems of Care in 2004.



PART B: Impact of Collaborative Systems of Care on the Larger Service System

Counties with Integrated Services Projects (ISP) and Coordinated Services Team Initiatives (CST) are asked to fill out an annual "Collaborative Systems of Care Update" survey which captures information on enrollment (summarized in Part A of this section) and the impact of their collaborative initiative on the larger service system (summarized below).

In this section, sites were asked to share their comments and recommendations in the following four areas:

- The positive and/or negative impacts of ISP/CST on other parts of the child and family service delivery system
- The cost effectiveness of ISP/CST
- Concerns, issues and challenges
- Recommendations for improvement

Below is a summary from 25 sites that completed the survey:

_____ **How has the formal collaborative system of care (ISP/CST) positively or negatively impacted other parts of the child and family service delivery system in your county?** _____

Positive Impacts:

Increased System Collaboration was identified by 13 Counties. Selected Comments:

School, law enforcement, and human service staff have participated on family teams in all communities at all grade levels. Transitions between communities and grades in school have improved.

Our program has established credibility in the community, providing service to the child, family, community, and schools. Child Protective Services and Juvenile Justice Divisions are now partners in providing services.

Positive Impacts on Families were identified by 12 counties. Selected Comments:

Families stay together as children are maintained in their communities.

Children and families can receive the services they need regardless of where they enter the system of care.

System of Care Expansion was identified by 6 Counties. Selected Comments:

In 2004, DHHS expanded its commitment to wraparound services in redesigning its Child and Family Services Unit. The emphasis for all ongoing casework is parent-centered collaborative teams. This expansion of the service coordination resource has provided a quick response to referrals to ISP by community partners. The goal of 50 operating teams by the end of 2004 was reached.

Access to Training/Inservice was identified by 5 counties. Selected Comments:

For the first time a training session was held for lawyers practicing in the county. Thanks to the sponsorship of the juvenile court judge, many attorneys attended. Participants learned the basics of ISP and are now aware of when and how they can participate on teams.

The implementation of CST has included agency-wide and community training regarding the principles and core values of CST.

Provider and Family Satisfaction was identified by 4 counties. Selected Comments:

Families are generally happy with the program.

Surveys indicate a high level of satisfaction from providers.

Creation of New Services was identified by 3 counties. Selected Comments:

The community collaboratively established three summer support options for students at-risk who have a wide array of physical, emotional, and cognitive needs.

Awards and Recognition were identified by 2 counties.

Negative Impacts were identified by **2 counties**. *Comments Include:*

- More pressure on existing resources resulting in need for more service providers.
- Lack of funding for needed services and frustration of families and providers as a result.

Is supporting the children and families in your ISP/CST cost effective?

Financial Savings were identified by all 25 counties. *Selected Comments:*

We hit an all-time high for out-of-home placements in CY 2002 at \$686,062. The out-of-home placement cost in CY 2004 was \$287,155 – a 42% decrease.

Over \$400,000 per year is saved by not having to place children in alternate care/CCI placements.

13 of the 14 children currently served are in their parental home. Using the lowest probable number for an out-of-home placement at \$1,400, this equals a cost savings of \$18,200.

Three children were in residential care at a cost of \$247 per day. One child returned home, and two have moved to Treatment Foster Care at a cost of \$2,200 per month.

The average cost of placement for a youth in a residential center is approx \$8,000 - \$8,500 per month. If even a fraction of the youth with SED served in 2004 had to be placed, the Substitute Care budget would have been overspent early in the year. We had only one youth that was removed from his parental home in 2004.

One family served in 2004 involved three children all with an SED diagnosis. Through the CCF process, all three children were maintained in foster care with community support, saving the county system over \$1,700/month.

Costs are averaging about \$1,500/month per family. Treatment foster care is \$2,000-3,000 per week, and hospitalization can cost up to \$15,000/month.

As of 11/30/04, we've spent \$20,610 on services to keep children in their homes. The estimated cost of out-of-home placement, either residential or treatment foster care would be \$167,640.

What concerns, issues, and challenges do you identify?

Sustainability and Expansion Issues were identified by **11 counties**. *Selected Comments:*

Community perception is that the department is responsible for support and service coordination services – need to work with the community toward system change.

Need to identify additional revenue options to support expansion and supplement our grant.

Systems Issues were identified by **9 counties**. *Selected Comments:*

Providing services (e.g. respite, summer camp, advocacy) to an increasing number of families and youth with mental health issues, with limited funding, resources, and staff.

Project partners continue to identify the challenge of finding time to devote to the team process.

Team Process Issues were identified by **8 counties**. *Selected Comments:*

Keeping teams strength-oriented, creative and flexible in planning.

Identifying and utilizing informal supports.

Data Collection and Paperwork was identified by **5 counties**. *Selected Comments:*

Increasing reporting demands create more work for social work, administrative, and support staff.

There is a need to improve the current data collection and maintenance system.

Training and Public Relations was identified by **4 counties**. *Selected Comments:*

Turnover in law enforcement, school administration, and social work staff continued. This creates a disruption in trained participation and administrative support.

Coordinating Committee Issues were identified by **4 counties**. *Selected Comments:*

Maintaining balanced coordinating committee membership that includes all important organizations and parent representation.

What recommendations do you make to improve your ISP process?

Coordinating Committee issues *were identified by 9 counties. Selected Comments:*

Continue to develop coordinating committee responsibilities – action committee, focus on sustainability.
Move toward systems change through the development of ISP at three levels: formal support, partner support, and family/friends/community support.

Training and Education *was identified by 7 counties. Selected Comments:*

Continue to educate collaborative community agencies on the benefits of the ISP process and provide training on identified needs.
Work with Wisconsin Family Ties to develop opportunities for parents to increase advocacy skills and become support and service coordinators.

Team Process Issues *were identified by 5 counties. Selected Comments:*

Work to improve our transition process.
Ensure ongoing adherence to CST values and process.

Data Collection and Paperwork *was identified by 5 counties. Selected Comments:*

Address redundancy of various collection systems.

Enhance Service Coordination *was identified by 5 counties. Selected Comments:*

Enhance service coordination services, including team member orientation and stronger leadership of teams.
Increase service coordinators throughout the agency for serving a variety of client populations.

Advocacy for Families *was identified by 3 counties. Selected Comments:*

Enhance social opportunities and advocacy for families.

Other Selected Comments:

Higher emphasis on cultural values and practices.
More networking with other ISP programs and outside agencies.
Increase emergency interventions and alternatives to hospitalization. Increase provider participation in expanding services for children with mental health.
Effort to reach the 5-year-old and under population.

GOALS AND EXPECTED OUTCOMES CHECKLIST

Upon receiving Coordinated Services Team Initiative (CST) funding, the 6 original CST (Calumet, Green Lake, Iron, Jefferson, Manitowoc, and Waupaca counties) sites and 4 CST sites added in 2003 (Bayfield, Marquette, Portage, and Sauk) were asked to complete the “Goals and Expected Outcomes Checklist” (GEOC) which evaluates each site in three areas:

- System outcomes supporting CST
- Process outcomes supporting CST
- Family-specific outcomes

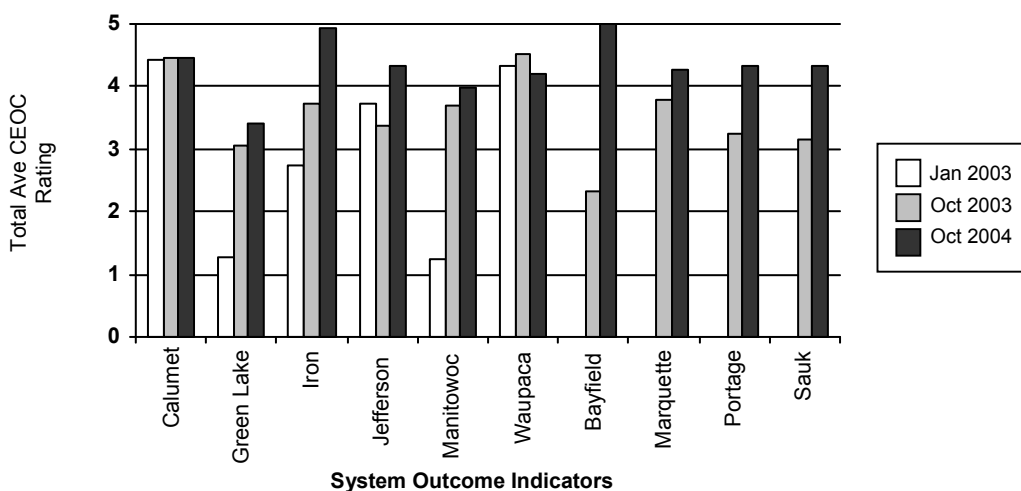
The Coordinating Committee (oversight and policy board) from each site was asked to rate their system of care on several indicators under each of the above three areas. Rating choices were as follows:

- 1 – Ready to begin
- 2 – Planning
- 3 – Initial implementation phase/learning
- 4 – Expanding implementation
- 5 – Fully developed/operational

The 6 original CST sites all completed the GEOC three times: first upon receiving their grants (January 2003), again in October 2003, and most recently in October 2004. The 4 sites in the second stream of funding completed their initial GEOCs in October/November 2003, and again in October 2004.

The chart below compares the overall average GEOC scores of each site over time. As shown, all but one site reported improvement in ratings from their initial completion of the GEOC to the present (October 2004). One explanation for the decrease in Waupaca County’s self-rating is the significant system expansion they experienced in 2004 – both within their human service system as well as throughout their law enforcement and educational systems.

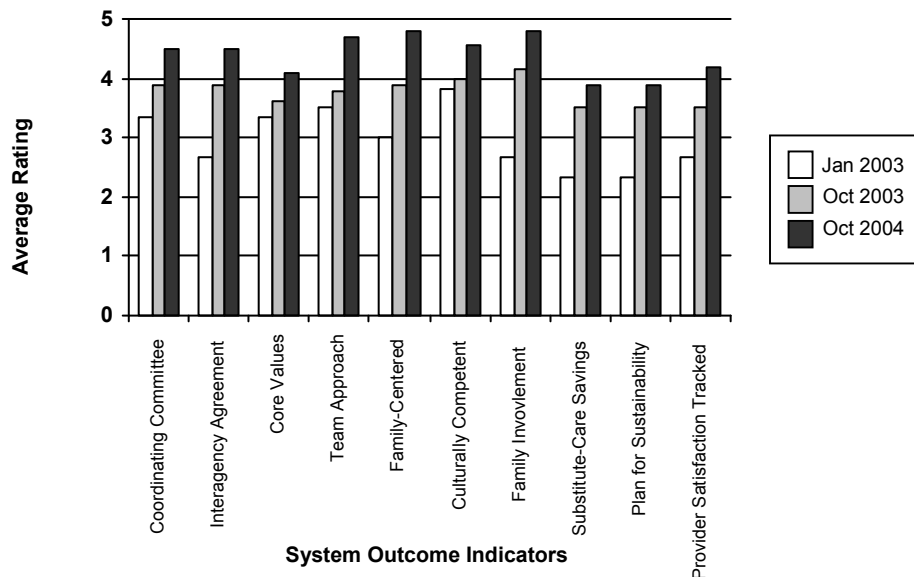
**Average Total Ratings on “Goals and Expected Outcomes Checklist”
January 2003, October 2003, and October 2004**



When considering the three broad areas sites were asked to rate themselves on: *System Outcomes, Process Outcomes, and Family-Specific Outcomes Supporting CST*, we see improvement in all areas over time.

The chart below compares average scores for each indicator related to system outcomes. As shown, the highest rated system outcome indicators across counties were: “team approach established”, “family-centered, strength-based services”, and “family involvement on Coordinating Committee and teams”. The areas consistently rated lowest were: “plan for sustainability is in place”, and “Substitute-Care Savings”.

**Average Total Ratings on For “System Outcomes” Indicators
January 2003, October 2003 and October 2004**



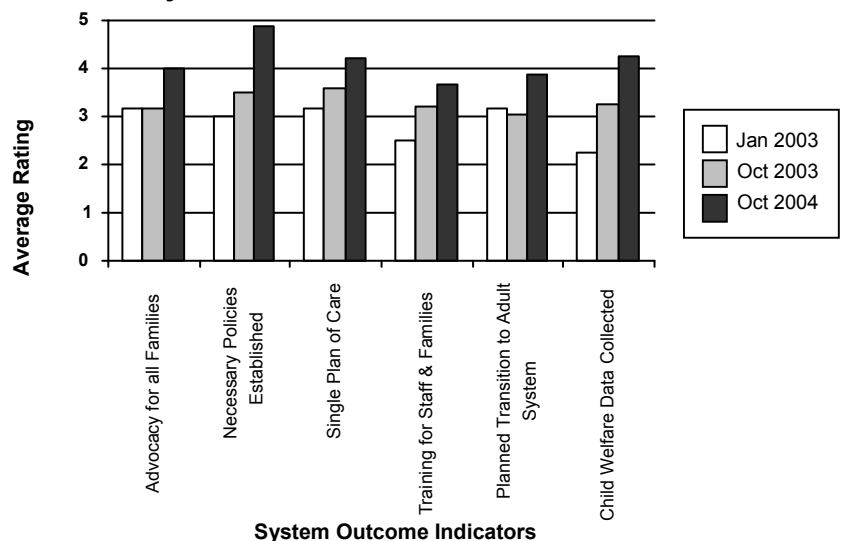
The chart to the right compares average scores for each indicator related to **process outcomes**.

Once again, all sites consistently show improvement over time.

“Necessary policies established” (i.e. referral, intake, service coordination, assessment, planning and transition) was an area of shared strength across sites.

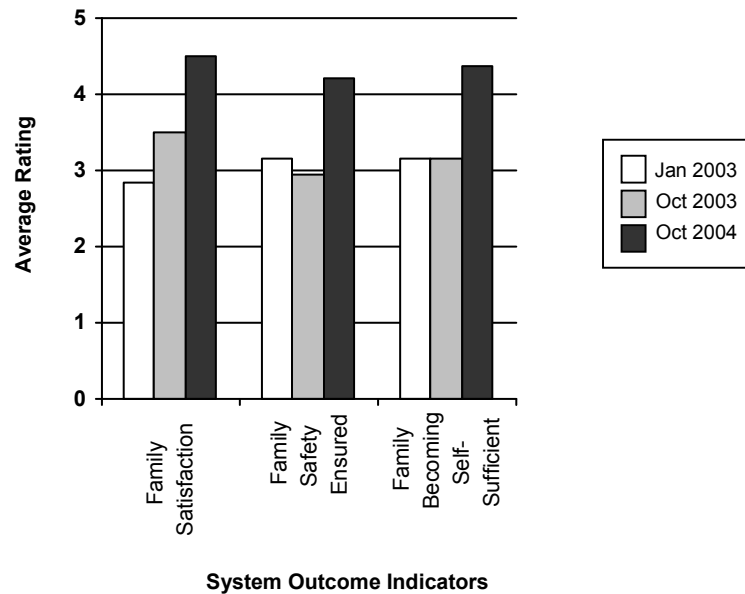
“Ongoing training for staff and families” was consistently rated lowest.

**Average Total Ratings on For “Process Outcomes” Indicators
January 2003, October 2003 and October 2004**



The chart below compares average scores for each indicator related to **family-specific outcomes**. All indicators in this area show notable increase from January 2003 to October 2004. The score given to the indicator “**Families are satisfied with the process**” increased 37% from Jan 2003 to Oct 2004. “**Family safety is ensured**” increased by 25%, and “families are achieving **self-sufficiency**” increased 28%.

**Average Total Ratings on For “Family-Specific Outcomes” Indicators
January 2003, October 2003 and October 2004**



FAMILY SATISFACTION SURVEY 2004

Families enrolled in Integrated Services Projects (ISPs) and Coordinated Services Team Initiatives (CSTs) across the State were asked to complete a Family Satisfaction Survey. The purpose was to gather information from a family perspective about areas of strength and need in collaborative systems of care serving children and families in Wisconsin. To encourage families' honest responses and to help ensure confidentiality, the surveys included stamped and addressed envelopes that families could return directly to Wisconsin Family Ties, a not-for-profit advocacy organization that tabulated the results.

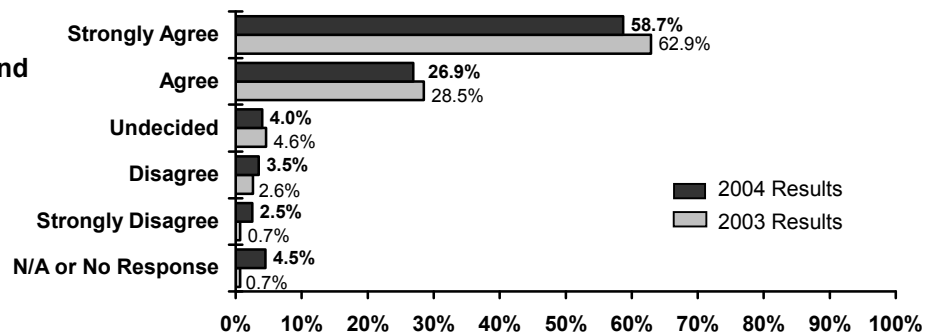
The survey consisted of 12 statements regarding satisfaction with different areas of the collaborative family team process. Families were asked to rate each statement using one of the following options:

- 1 – Strongly Disagree
- 2 – Disagree
- 3 – Undecided
- 4 – Agree
- 5 – Strongly Agree
- Not Applicable

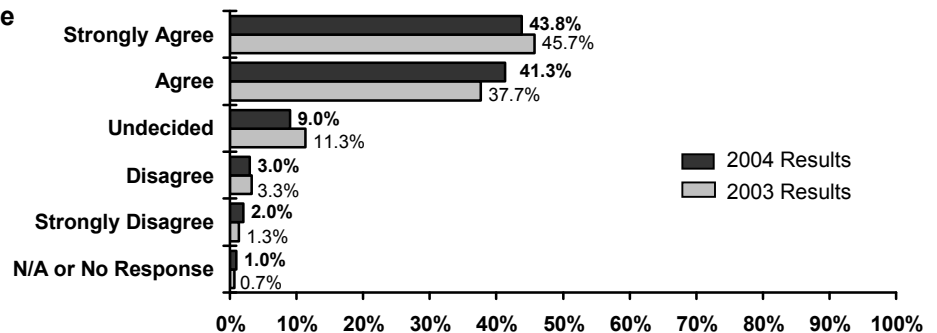
205 surveys were returned and tabulated in 2004, a 48.8% return rate; compared with 151 surveys returned in 2003, a 47.6% return rate.

Following is a summary comparing 2004 and 2003 results:

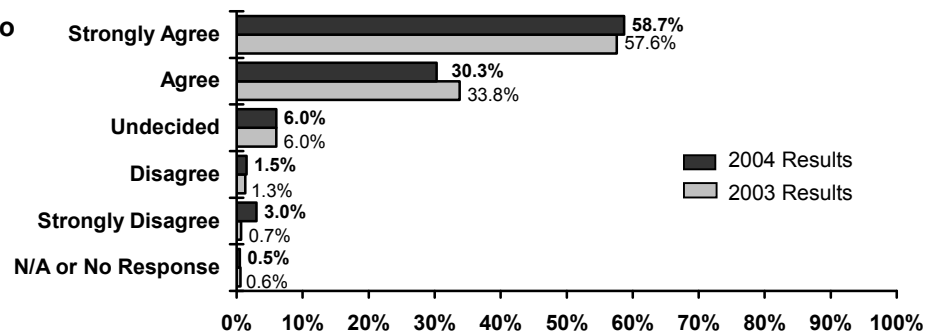
1. I feel I am treated as an important member of my child and family team.



2. I am satisfied with the goals the team and I have set.

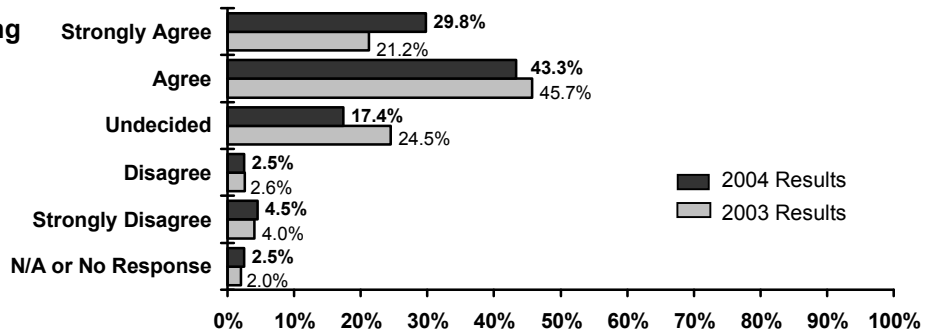


3. The team takes time to listen to my concerns.

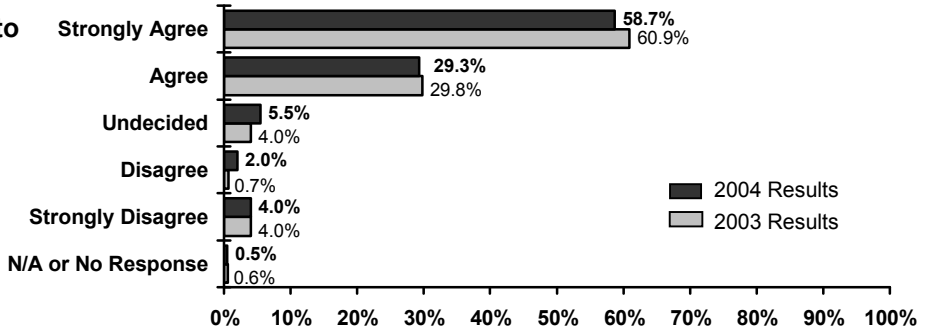


Family Satisfaction Survey 2004

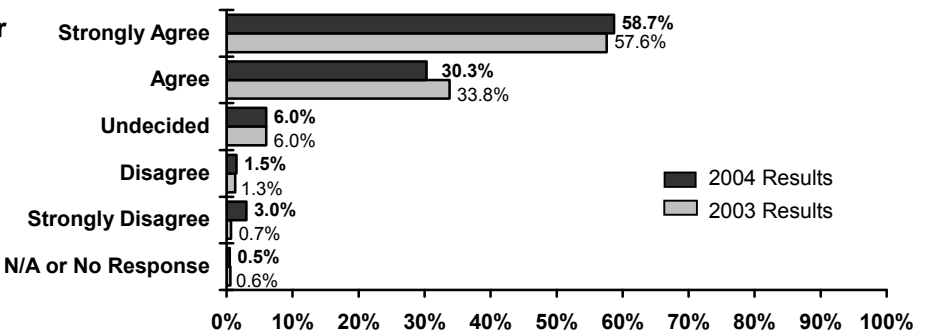
4. My family is getting better at coping with life and its daily challenges.



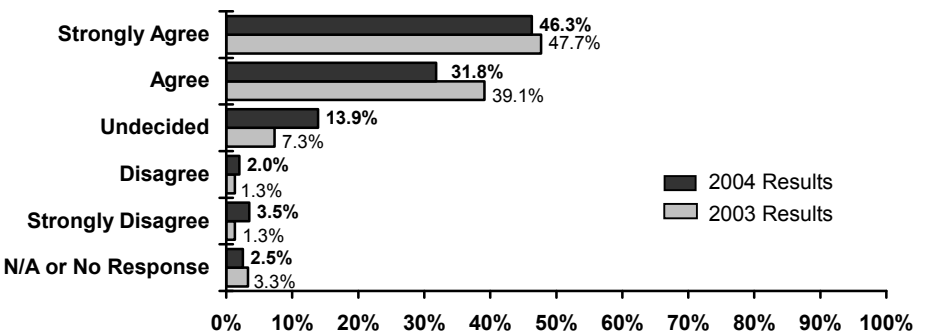
5. I would refer another family/child to the Integrated Services Project.



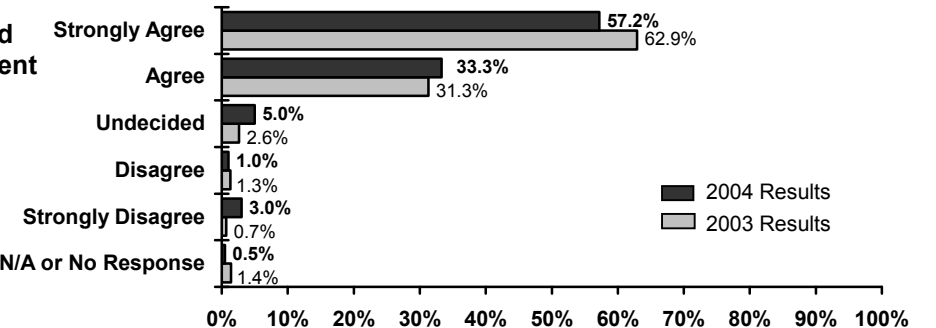
6. My care coordinator speaks up for my child and family.



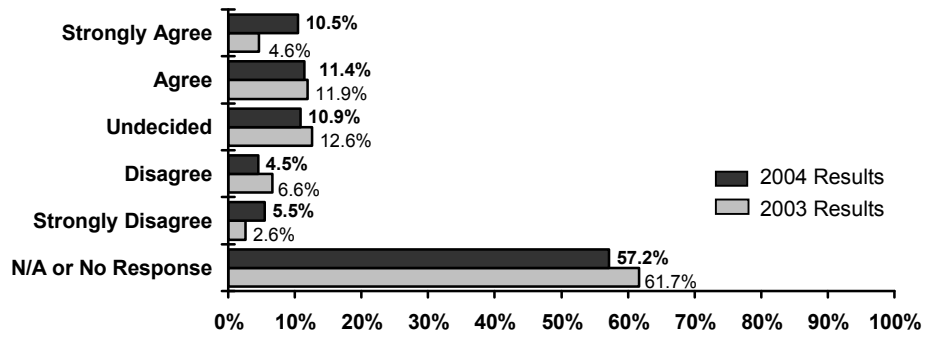
7. The team is sensitive to my cultural, ethnic, and religious preferences and values.



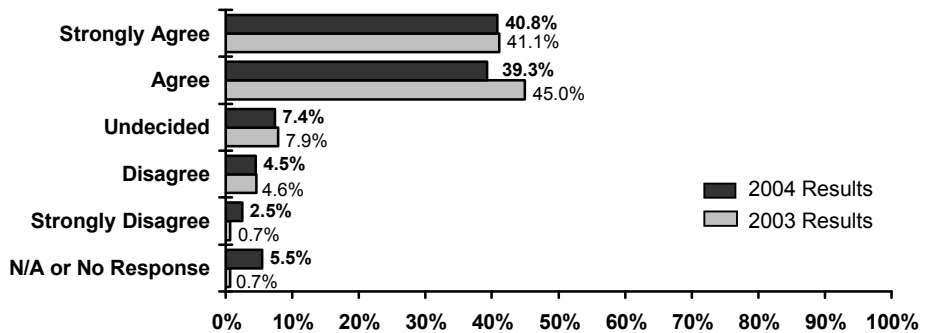
8. The team schedules services and meetings at times that are convenient to my family and me.



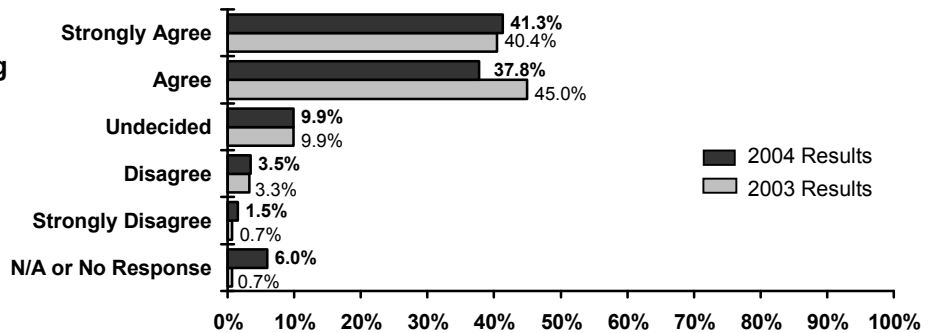
9. If my child is 14 or older, the team has a plan to insure he/she can get needed services when 18.



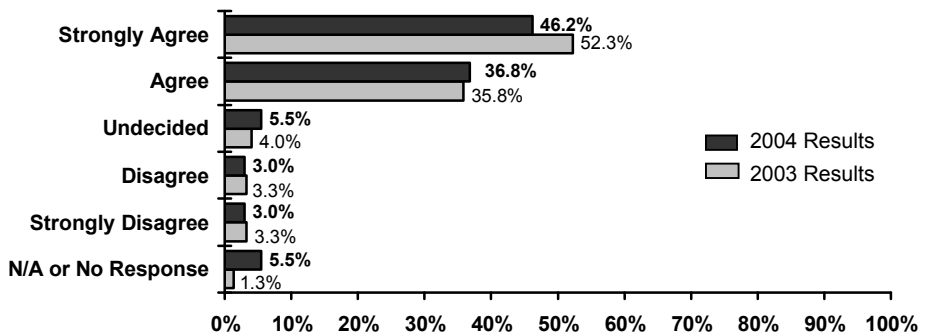
10. I feel the team understands my child's strengths and needs.



11. I know the team uses my child's strengths in setting goals and making plans.



12. Overall, I am satisfied with the efforts of the team on my family's behalf.



8 KEY COMPONENTS OF COLLABORATIVE SYSTEMS OF CARE 2004

As a part of their annual reporting requirements, each of the Coordinated Services Team Initiatives and Integrated Services Projects are asked to complete a self-report measuring how well they met the eight key process and outcome areas that are important in maintaining a successful collaborative system of care. In completing the report, sites are asked to gather information from Project Coordinators, Service Coordinators, Families, and Coordinating Committee Members.

The Eight Key Components of Collaborative Systems of Care:

1. Parents/caregivers are involved as full partners at every level of activity
2. An inclusive interagency group (Coordinating Committee) serving children and families has agreed upon the Core Values and Guiding Principles of Collaborative Systems of Care which are outlined in an Interagency Agreement
3. Collaborative family teams create and implement individualized support and service Plans of Care for families
4. Significant collaborative funding is available to meet the financial needs identified in the Plan of Care
5. Advocacy is provided for each family
6. Ongoing training is provided to all participants
7. Functional goals are monitored and measured, emphasizing participant satisfaction
8. Adolescents are ensured a planned transition to adult life

*Following is a summary of the responses of 26 sites that completed the report.
For most indicators, sites were asked to chose a response from a likert scale; responses that differ (e.g. "yes/no" responses) are noted.*

1. Parents* are involved as full partners at every level of activity (*The term "parent" represents all caregivers)				
Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
Team Participation				
1. Parents may request meetings.	100%	0%	0%	0%
2. Parents are present @ team meetings. Children are present whenever possible and appropriate.	88%	12%	0%	0%
3. Parents' needs are considered in scheduling meetings.	79%	21%	0%	0%
4. Parents are involved in selection of team members.	88%	8%	4%	0%
Coordinating Committee Participation				
1. Parents on Coordinating Committee and appropriate subcommittees	92% - YES			8% - NO
2. Parents attend at least 75% of scheduled Coordinating Committee meetings.	26%	35%	30%	9%
3. Parents feel they are listened to by other committee members and that they have an important role on the committee.	25%	70%	0%	5%

2. An inclusive interagency group (Coordinating Committee) serving children and families has agreed upon the core values and guiding principles of Collaborative Systems of Care which are outlined in an Interagency Agreement.

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Agreement incorporates all the members and components listed under State Statute 46.56 (3) (5).	92% - YES			8% - NO
2. The Coordinating Committee reviews interagency agreements at least every three years.	90% - YES			10% - NO
3. Coordinating Committee meets at least quarterly.	88% - YES			12% - NO
4. Conflict resolution policies are clearly written and reviewed at least annually.	91% - YES			9% - NO
5. Conflict resolution policies are followed when disagreements arise.	100% - YES			5 – “not used yet”
6. The Coordinating Committee assures that the core values and guiding principles are evident in the operation of the integrated services system of care.	63%	29%	8%	0%
7. Collaborating agencies are satisfied with process.	33%	67%	0%	0%

3. Collaborative family teams create and implement individualized support and service Plans of Care for families

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Orientation is provided to all team members.	82% - YES			18% - NO
2. Team facilitator and/or service coordinator receive training and support.	79%	21%	0%	0%
3. Collaborative family team includes membership from home, school and community.	57%	43%	0%	0%
4. Team composition is consistent with family culture and preferences.	70%	30%	0%	0%
5. Family is satisfied with its team.	42%	54%	4%	0%
6. Family is satisfied with the team process.	25%	75%	0%	0%
7. Process is a collaborative team effort that begins with an individualized strengths- and needs-based assessment.	58%	42%	0%	0%
8. Plan of Care flows from assessment.	62%	38%	0%	0%
9. Plan of Care incorporates strengths of child, family and team.	52%	43%	5%	0%
10. The Plan of Care includes specific actions to meet identified needs, including who is responsible (including parents) for completing the action, and the plan is being followed.	54%	42%	4%	0%

3. Collaborative family teams create and implement individualized support and service Plans of Care for families (Continued)				
Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
11. Family and other team members sign the Plan of Care.	92% - YES			8% - NO
12. Transition is addressed for major life changes.	52%	35%	13%	0%

4. Significant collaborative funding is available to meet the financial needs identified in the Plan of Care				
Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Agencies contribute resources and funding to meet the needs of families.	33%	38%	29%	0%
2. Child and family teams use funding flexibly to support individualized service.	50%	46%	4%	0%
3. Child and family team accesses informal community resources.	41%	46%	13%	0%

5. Advocacy is provided for each family				
Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Family advocacy information and options are provided.	80% - YES			20% - NO
2. Advocates may participate as team members as requested by the family.	95% - YES			5% - NO
3. Service Coordinators advocate for families	80%	20%	0%	0%

6. Ongoing training is provided to all participants				
Indicators				
1. Coordinating Committee and Project Coordinator identify training needs on an ongoing basis.	96% - YES			4% - NO
2. Annual local training opportunities are made available to families, staff, and all others involved with the ISP process.	100% - YES			0% - NO

7. Functional goals are monitored and measured, emphasizing participant satisfaction				
Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Generally, Outcomes show: <ul style="list-style-type: none"> Decrease in police contact/recidivism rates Maintenance or decrease in level of restiveness of living environment Improvement in grades Improvement in attendance Decrease in problem behaviors 	100% - YES			0% - NO
	100% - YES			0% - NO
	94% - YES			6% - NO
	100% - YES			0% - NO
	100% - YES			0% - NO
2. Plan reviews are held at least every six months.	100% - YES			0% - NO
3. Family is satisfied with process.	33%	67%	0%	0%
4. Family is satisfied with outcomes.	30%	70%	0%	0%
5. Providers are satisfied with process.	28%	64%	8%	0%
6. Providers are satisfied with outcomes.	22%	70%	8%	0%

8. Adolescents are ensured a planned transition to adult life				
Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. A mechanism is in place to identify children age 14 and older who have long-term treatment needs and who will require services beyond age 18.	95% - YES			5% - NO
2. Plans of care reflect collaborative transitional planning for children age 14 and older identified as needing services beyond age 18.	100% - YES			0% - NO
3. For the most seriously ill adolescents, within one year of transition to adult living: <ul style="list-style-type: none"> Action steps are clearly defined Needed referrals have been made Future collaborators are invited to team meetings 	68%	27%	5%	0%
	71%	24%	5%	0%
	70%	25%	5%	0%